Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN657HOS1	A. BUILDING _____ B. WING _____	06/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN REHABILITATION HOSPITAL	555 GOULD ST RENO, NV 89502

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S 000	Initial Comments This Statement of Deficiencies was generated as a result of a State Licensure re-survey conducted in your facility on 6/1/09 and finalized on 6/4/09, in accordance with Nevada Administrative Code, Chapter 449, Hospitals. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following deficiencies were identified.	S 000	RECEIVED JUL 24 2009 BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA	
S 070 SS=D	NAC 449.3154 Construction Standards 1. Except as otherwise provided in this section, a hospital shall comply with the provisions of NFPA 101: Life Safety Code, pursuant to section 1 of this regulation. This Regulation is not met as evidenced by: The current edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) is the 2006 edition, Chapter 18 New Health Care Occupancies. This REG is not met as evidenced by: 1) 18.2.3.4 Aisles, corridors, and ramps required for exit access in a hospital or nursing home shall be not less than 8 ft (2440 mm) in clear and unobstructed width, unless otherwise permitted by the following: Based on observation, the facility failed to maintain pre-existing corridors used as exit access.	S 070	**TAG S 070 1) 18.2.3.4 (p 1/13)** Construction Standards Effective August 1, 2009, Computers, medication carts, equipment will be removed from hallway when not in use and placed in the following designated areas: (1) East Nurses Station (general nursing) - East Hall Conference room (former T-dine room); Central and TBI hallways - TBI supply room (former wheelchair storage room). Compliance with storage of equipment (i.e., COW, med cart, Dynamap) when not in use will be monitored by leadership during rounding and the Charge Nurse during hours when only nursing staff is present. Attachments: **Tag S070 1) (p 1/13)** 1. Map of storage area for med carts and computers	7/30/09

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

7/23/09

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S 070	Continued From page 1 Findings include: In the corridor in front of the west nurses station there was a med cart and a computer stored reducing the corridor width from 8 ft to 6 ft. In the corridor in front of the east nurses station there was a med cart stored reducing the corridor width from 8 ft to 6 ft. In the corridor north of the east nurses station there was a med cart stored reducing the corridor width from 8 ft to 6 ft. 2) Alarms, emergency communications systems and illumination of generator set locations are in accordance with NFPA 70.9.1.2. Based on observation, the facility failed to provide illumination of the generator set location. Findings include: The generator set location did not have a battery back-up light to illuminate the location upon the failure of city power and generator failure. 3) 18.7.1 Evacuation and Relocation Plan and Fire Drills 18.7.1.6 Drills shall be conducted quaterly on each shift to familiarize facility personal (nurses, interns, maintenance engineers, and administrative staff) with signals and emergency action required under varied conditions. Based on record review, the facility failed to maintain records of fire drills conducted. Findings include:	S 070	**TAG S 070 2) NFPA 70.9.1.2. (p 2/13)** An emergency battery operated flood light will be installed in the generator area. Vendor contacted with battery-powered light ordered. Delivery and installation anticipated to be completed by 07/31/09. **TAG S 070 3) 18.7.1 (p 2/13)** Fire drills There is a gap of approximately 8 months in the 2008 fire drill records due to management turnover in the department and being unable to locate the historical documents. Documents prior to 1/08 and after 10/08 are on file in the maintenance shop. The Safety Officer, Terry Thomas, is responsible for compliance with fire drills (1 fire drill per shift per quarter), which is validated by the Renown Health Director of Facility/Engineering. The last fire drill was 5/29/09 and will continue quarterly.	

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S 070	Continued From page 2 The facility did not have documentation of a fire drill conducted for the 2nd quarter of 2008 on day shift and the 3rd quarter of 2008 on night shift. 4) 9.1 Utilities 9.1.3 Emergency generators and standby power systems, where required for compliance with this code, shall be installed , tested , and maintained in accordance with NFPA 110, Standards for Emergency and Standby Powers Systems. NFPA 110 8.4.3 Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent nameplate rating for 30 minutes, followed by 75 percent nameplate rating for 60 minutes, for a total of 2 continuos hours. Based on record review, the facility failed to perform the required annual 2-hour load bank test for the emergency generator and 30 minute per month tests under load. Findings include: The facility did not have a record of an annual 2-hour load bank test for 2008. The facility did not have records of 30 minute monthly testing for June 2008 thru January 2009. Severity: 2 Scope: 1	S 070	**TAG S 070 4) 9.1 (p 3/13)** generator testing There is a gap of approximately 8 months in the 2008 generator testing records due to management turnover in the department and the historical documents records could not be located. Monthly test documents prior to 6/08 and after 01/09 are on file in maintenance shop. The Safety officer is responsible for compliance with generator testing. The 2008 generator testing document was retrieved from the vendor and is attached. Generator testing will be done in accordance with NFPA 11D, Standards for Emergency and Standby Power Systems: Annual 2-hour load back and 30 minutes per month tests under load. Attachments: **Tag S070 4) (p 3/13)** 1. 2008 generator load testing (3 pages) Acceptable Robert Cain 7/20/09	
S 088 SS=D	NAC 449.316 Physical Environment 1. The buildings of a hospital must be solidly constructed with adequate space and safeguards	S 088	**TAG S 088 1) #1-6 NAC 449.306 (p 3/13)** (Detail on page 4/13)	

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S 088	Continued From page 3 for each patient. The condition of the physical plant and the overall hospital environment must be developed and maintained in a manner so that the safety and well-being of patients are ensured. This Regulation is not met as evidenced by: Based on observation and interview the facility failed to ensure all electronic equipment was inspected as required and failed to safely store equipment. 1. Automatic external defibrillators on crash carts on nursing units were due for inspection 4/09 and 6/09. 2. Dinamap in special procedures unit was due for inspection 9/08. 3. Bladder scanner located in hall in front of room 118 due for inspection 5/09. 4. The following items were located in the physical therapy room: two hot hydrocollators due for inspection 9/08 and the pulse oximeter due for inspection 9/08. 5. Five Flexiflo Patrol feeding pumps did not have bio med tags identifying their last inspection. 6. Five wheelchairs and two walkers blocked a door which contained a sign indicating it was not to be blocked due to the smoke alarm and reset panel. Severity: 2 Scope: 2	S 088	**TAG S 088 1) #1-6 NAC 449.306 (p 3-4/13)** The equipment identified has been inspected, and properly tagged by clinical engineering and is now up to date. Monthly departmental inspection of medical equipment inspection will be beginning August 1, 2009. Departmental managers or supervisors will complete Monthly Medical Equipment Inspection Log and send to Supervisor of Plant Operations. Plant operations will contact clinical engineering for inspection of equipment. Attachments: **Tag S088 1) #1, 3, 4, 5 (p 4/13)** 1. Monthly medical Equipment Inspection Log **TAG S088 1) # 6 (p 4/13)** Wheelchairs and walkers removed from Outpatient Wheelchair storage, which was designated by sign not to block access to smoke alarm and reset panel. Additional signage to keep area clear will be completed by the Safety Officer by 07/31/09. **TAG S088 1) # 1, 2 (p 4/13)** The special procedures equipment identified has been inspected and properly tagged by clinical engineering and is now up to date. Logs for Weekly cleaning/equipment inspection/repair, Daily Crash cart checks, and Temperature monitoring have been developed or revised and will be effective 8/1/09 for tracking. The interim Special Procedures overseer will monitor for compliance on a weekly basis X 4, then monthly thereafter. Attachments: **Tag S088 1) # 1, 2 (p 4/13)** 1. Weekly cleaning/Inspection Log 2. Daily Crash Cart Checklist 3. Daily Refrigerator Temperature Log 4. Daily Blanket Warmer Temperature Log	
S 202 SS=E	NAC 449.3395 Sanitary Conditions - Supplies for Food 2. A hospital shall maintain on its premises at least a 1-week supply of staple foods and at least a 2-day supply of perishable foods. The supplies must be appropriate to meet the requirements of the menu. All food must be of good quality and	S 202	**TAG S 202 2) NAC 449.3395 (p 4-5/13)** Sanitary Conditions – Supplies for Food Sugar container is now labeled. Fruit salad is now dated and labeled. Raw eggs stored on separate shelf with no other foods allowed. Staff has been educated. Have hired contracted services, the Food Safety Network (Tony Pastini) to help educate staff on food borne illness, cross-contamination, food safety and sanitation. FNS manager will monitor compliance of inspections by staff. Attachments: **Tag: S 202 2) (p 4-5/13)** 1. Copy of contract with Food Safety network – Tony Pastini	

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S 202	Continued From page 4 procured from sources approved or considered satisfactory by federal, state and local authorities. Food that is contained in a container or can that: (a) Is unlabeled, if the contents of the container or can are not readily identifiable without opening the container or can Is not acceptable and must not be maintained. This Regulation is not met as evidenced by: Based on observation the facility failed to label a bulk container of sugar, failed to label and date a container of fruit salad, and failed to store raw eggs in a manner which would prevent contamination of adjacent foods. Severity: 2 Scope: 2	S 202		
S 205 SS=E	NAC 449.3395 Sanitary Conditions - Supplies for Food 3. All kitchens and kitchen areas in a hospital must be kept clean, kept free from litter and rubbish, and protected from rodents, roaches, flies and other insects. The hospital shall take such measures as are necessary for preventive pest control. All utensils, counters, shelves and equipment must be kept clean, maintained in good repair, and free from breaks, corrosions, open seams, cracks and chipped areas. Plastic ware, china and glassware that is unsightly, unsanitary or hazardous because of chips, cracks or loss of glaze must be discarded. This Regulation is not met as evidenced by: Based on observation the facility failed to ensure cleanliness of the kitchen by: spilled milk on the floor of the walk-in refrigerator, spilled topping on the floor of the dry storage, and grease on the floor behind the fryers. The interior of the microwave also needed cleaning.	S 205	**TAG S 205 3) NAC 449.3395 (p 5-6/13)** Sanitary Conditions – Supplies for Food All areas and surfaces have been cleaned and sanitized. Employees have been educated. FNS manager has developed daily and weekly sanitation inspection reports and they will be in place beginning 8/1/09. Contracted services have been hired to help educate employees on food safety and sanitation. FNS manager will monitor compliance of inspections by staff. (See attachment Tag S 202 2)) Attachments: Tag S 205 3) (p 5/13) 1. FNS Daily Inspection Checklist 2. FNS Weekly Inspection Checklist	

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S 205	Continued From page 5 Severity: 2 Scope: 2	S 205		
S 212 SS=E	NAC 449.3395 Sanitary Conditions - Supplies for Food 9. Equipment of the type and in the amount necessary for the proper preparation, service and storage of food and for proper dishwashing must be provided and maintained in good working order. This Regulation is not met as evidenced by: Based on observation the facility failed to provide commercial grade dietary equipment. 1. The main nursing nourishment refrigerator 2. Therapeutic dining room room refrigerator and microwave Severity: 2 Scope: 2	S 212	**TAG S 212 NAC 449.3395 (p 6/13)** Sanitary Conditions – Supplies for Food FNS: Corrective action: The main nursing nourishment room refrigerator was replaced with a commercial grade refrigerator on 6/20 /09. NSF UL approved. Therapeutic Dinning room refrigerator and microwave has been replaced with commercial grade on 6/20/09. NSF UL approved.	
S 216 SS=D	NAC 449.340 Pharmaceutical Services 2. The pharmacy and area for drug storage must be administered in accordance with all applicable state and federal laws. This Regulation is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to discard medication that was beyond it's expiration date, failed to discard medication that was brought to the facility from an outside source and failed to obtain medication for patient use as per facility policy. A multi-dose vial of Phenol from an outside pharmacy with an expiration date of 3/25/09, was found in the special procedures unit refrigerator and a nurse reported she believed it was brought into the facility by a physician on 5/28/09. Review	S 216	**TAG S 216 NAC 449.340 (p 6/13)** Pharmaceutical Services Special procedures staff nurses were verbally counseled 06/11/09 regarding out-of-date phenol in refrigerator. Reviewed dispensing medication policy regarding medications brought into hospital from outside source, which states medications brought in from outside of the hospital must be checked by pharmacy prior to administration. The Rehab Hospital Executive Director and Medical Director, on 6/11/09, sent notification to all physicians practicing in the Special Procedures department regarding bringing medications into the hospital and the proper process to follow. Attachments: **Tag S 216 (p 6/13)** 1. Dispensing medications policy: SMeadows.CID.560 2. Email from Kevin Desmond, Rehab Hospital Pharmacy manager 3. Letter to Special Procedures physicians dated 6/11/09	

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S 216	Continued From page 6 of patient records revealed that Patient #21 was injected with Pheno 10% during a Radiofrequency lesioning on 5/28/09, in the special procedure unit. The nurse denied any knowledge that the vial of expired Phenol was used during the procedure. Severity: 2 Scope: 1	S 216	**TAG S 219 NAC 449.340 5.2 POC (p 7-8/13)** Pharmaceutical Services 5.2 POC: All expired IV bags are removed. Pharmacy has developed a list of all IV solutions kept in the IV solution storage room. The list contains the nearest expiration date of each type of solution. Pharmacy staff will inspect the IV solution storage room monthly for any possible expiring solution. All such solutions shall be removed and destroyed. The hospital pharmacists will monitor compliance with monthly inspection of IV solution and documentation on IV storage inspection log. Attachment: **Tag S219 5.2** 1. Pharmacy Monthly IV Solution Inspection Log	
S 219 SS=D	NAC 449.340 Pharmaceutical Services 5. Drugs and biologicals must be controlled and distributed in a manner which is consistent with applicable state and federal laws. This Regulation is not met as evidenced by: Based on observation and interview the facility failed to ensure expired medications were removed from stock and that a system existed for monitoring the 60 days shelf life for vials of Lorazepam. 1. Three vials of Diazepam 10 mg (milligrams)/2ml (milliliters), six vials of Sterile Water and one vial of Lidocaine HCL 1.5% with Epinephrine found in special procedures cart with expiration dates of 5/1/09. 2. Ten one liter bags of .45% Normal Saline (expiration 6/1/09), nine one liter bags of Lactated Ringers (expiration 6/1/09), and two one liter bags of D5 (Dextrose 5%)Normal Saline (expiration 4/1/09) were found in the storage room. 3. Five Epinephrine 1:10,000 injection were found on the special procedures crash cart with expiration dates of 5/9/09. 4. One syringe of Dextrose 50% was found on the special procedures cart was found with an expiration date of 5/08. 5. One vial of Phenol Injectable NS 10% was found in the special procedures medication	S 219	**TAG S 219 5.1, 5.3, 5.4, 5.5, 5.6 (p 7-8/13)** Special Procedures All medications in Special procedures have been inspected checked with removal of expired medication. An inventory has been compiled on all medications for expiration dates in the crash cart, procedure carts, cabinet, and medication refrigerator. Logs have been setup for checking medication expiration date by staff and will start 8/1/09. The Special Procedures interim department overseer (Quality Consultant) will monitor compliance by checking the logs for documentation of checking for expired medication. Attachments: **Tag S219 5.1, 5.3, 5.4, 5.5, 5.6 (p 7/13)** 1. Special Procedures Cart I Medication Expiration Log 2. Special Procedures Cart II Medication Expiration Log 3. Special Procedures Crash Cart Drawer Medication Expiration Checklist 4. Special Procedures Crash Cart Medication Expiration Log 5. Special procedures Refrigerator/Stock/Cabinet Medication Expiration Log 6. Special Procedures Monitoring Check Sheet **S 219 NAC 449.340 5.7 POC (p 8/13)** All non-dated Lorazepam vials have been removed and quarantined for return via return company. Effective 6/5/09 all subsequent vials of Injectable Lorazepam will be individually dated for 60 days within the MedSelect machine and the nearest expiration date shall be entered into the MedSelect computer. The med-select computer is checked monthly for outdating meds. Any outdating Lorazepam shall be removed and the next nearest expiration date will be entered into the system for subsequent removal at such time of expiration. The removed Lorazepam shall be isolated for return via return company. The undated Lorazepam found during the survey in MedSelect was removed at that time.	

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S 219	Continued From page 7 refrigerator with an expiration date of 3/25/09. 6. Two vials of Hyaluronidase Injection were found in the special procedures unit refrigerator with expiration dates of 4/29/09. 7. Per the manufacturer, Lorazepam remained stable for 60 days at room temperature. There was no system to determine the length of time the Lorazepam was at room temperature in the MedSelect dispensing unit. Severity: 2 Scope: 1	S 219	**TAG S 219 5.6, 5.7 (see page 7/13)**	
S 293 SS=F	NAC 449.361 Nursing Services 4. A hospital shall have a system for determining the nursing needs of each patient. The system must include assessments made by a registered nurse of the needs of each patient and the provision of staffing based on those assessments. This Regulation is not met as evidenced by: Based on interview and policy review, the facility failed to have an acuity based staffing system based on assessment of patients needs. An interview with the clinical nurse manager and a review of the staffing matrix revealed staffing patterns were based on daily patient census of the facility. The manager was able find staffing information from 2004 which was based on individual assessment of each patient with designated hours of nursing based on the assessment. The clinical manager indicated that the system from 2004 was no longer in use. All of the managerial staff had changed since 2004 and none of the staff knew why the acuity based staffing system was discontinued. Severity: 2 Scope: 3	S 293	**TAG S 293 NAC 449.361 (p 8/13)** Nursing Services Renown Health System has PIN system in place in the electronic medical record (EPIC). The assessment of patient intensity of need and staff resource utilization system (Patient Intensity of Need - PIN system) will be added by 8/1/09 to Rehab computer system in order for classification of patient acuity for staffing to be implemented. Patients are PINed on admission and each shift (prior to 4pm and 4am). A printout assists with staffing by acuity. (See Smeadows.NA.100 policy) Education Plan for Rehab staff on PIN system will be initiated on 8/3/09 and consists of the following: a. Rehab staff will have PIN system educational training by South Meadows CNS and Renown Regional Educational Specialist. b. Follow-up will include coordinated education plan and working with nursing leadership on ongoing education. c. Online Learning System (OLA) Module for all rehab licensed staff d. Creation of PIN system "Superusers" from staff for support Attachment: **Tag S293 (p 8/13)** 1. Policy: Smeadows.NA.100	

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S 300 SS=F	NAC 449.3622 Appropriate Care of Patient 1. Each patient must receive, and the hospital shall provide or arrange for, individualized care, treatment and rehabilitation based on the assessment of the patient that is appropriate to the needs of the patient and the severity of the disease, condition, impairment or disability from which the patient is suffering. This Regulation is not met as evidenced by: Based on record review and interview the facility failed to ensure care plans were individulized or updated to the appropriate needs of the patients (Patient #2, 5, 16, 18, 8, 13,19) Findings include: 1. Care plan for Stage II pressure sore for Patient #2 was not updated to include improvement of the wound. 2. Patient #5 was admitted with dysphagia, and had no care plan to advise of the changes in diet/swallowing status or current NPO (nothing by mouth) status. A certified nursing assistant was heard asking the nurse if Patient #5 could have ice chips as a family member was giving ice chips to the patient. The patient was strict NPO due to aspiration risks. 3. Patient #16 was observed to have a Jackson trach with instructions of the front of the chart. No care plan was in place for care of the Jackson trach. 4. Patient #18 was admitted 3/11/09. The care plans for Patient #18 were last updated 4/22/09.	S 300	**TAG S 300 NAC 449.3622 (p 9, 10, 11/13)** Appropriate Care of Patient The correction plan for assessment and reassessment for appropriateness will consist of the following with implementation of plan by 8/3/09: a. Review and revision of Assessment/ Reassessment policy (Smeadows.CID.250) for application to Rehab hospital b. Update specific NCP for Rehab Nursing Care Plan (NCP) documentation of appropriate care of the patient c. Revision of Nursing Care Plan forms to include documentation of patient condition and review each shift. NCP forms will be filed in the patient's chart under the tab: Nursing Care Plan d. Staff will receive mandatory education on new process and documentation of appropriate care of patient. e. Each patient will have appropriate NCP completed for identified problems and will be reviewed/updated each shift f. Monitoring of nursing documentation of appropriate care of patient will be performed by weekly random chart audit totaling 30 charts per month Attachments: **Tag: S 300 (p 9, 10, 11/13)** 1. Policy: Smeadows.CID.250 Assessment/Reassessment 2. Example of updated form for NCP Check Sheet	

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S 300	Continued From page 9 5. Patient # 8 was admitted to the facility on 5/20/09 and readmitted on 5/30/09 after a two day acute hospital stay from 5/27/09 to 5/30/09. The patient's daignoses included status post mitral valve replacement, pacemaker, atrial fibrillation, chronic obstructive pulmonary disease, pancreatic pseudocyst, anemia, and leukocytosis. A document labeled Call Report Sheet indicated the patient had stage 1 and stage 2 pressure ulcers on the buttocks. A review of the medical record revealed photographs of the pressure ulcers on both admissions. A review of the careplan revealed there was no mention of the pressure ulcers. A review of the admission screening form revealed there was no mention of any wounds. A review of the admission orders revealed an order for Beck's butt balm to the affected area on 5/21/09. Daily progress notes from 5/21/09 to 6/1/09 revealed the skin assessment indicated skin intact or was left blank. Readmission on 5/30/09 revealed no new orders for treatment of the pressure ulcers. The only intervention noted on either admission was the Beck's butt balm and a nutritional assesment for supplements to increase wound healing. The photograph of the wounds taken on readmission did not include measurements although the wounds appeared larger. Interview with the charge nurse on the unit revealed the patient did not have any pressure relieving devices on the patient's bed or wheelchair. The nurse indicated referral for wound care assessment was made when a wound was stage three in developement. The nurse indicated staff was applying a barrier	S 300		

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN657HOS1	A. BUILDING _____ B. WING _____	06/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 300	Continued From page 10 cream to the affected area currently. The nurse indicated the wounds should have been written on the care plan. A review of the wound care assessment policy indicated the skin care resource team represented by staff nurses from each unit was available and a staff nurse could request a consult from the team without a physician order. The policy also indicated if no specific wound care orders were written, saline dressings were applied until physician was contacted for specific orders. None of this protocol was in evidence. 6. Patient #13 had a rash with an ulceration in the groin area and the care plan did not identify nursing goals or interventions designed to resolve the problem 7. Patient #19 had dysphagia but his care plan was not updated to reflect changes in his diet and in the supervision he required during mealtime. Severity: 2 Scope: 3	S 300		
S 310 SS=D	NAC 449.3624 Assessment of Patient 1. To provide a patient with the appropriate care at the time that the care is needed, the needs of the patient must be assessed continually by qualified hospital personnel throughout the patient's contact with the hospital. The assessment must be comprehensive and accurate as related to the condition of the patient. This Regulation is not met as evidenced by: Based on record review and interview, the facility failed to continually reassess the needs of patient #8 throughout the hospital stay.	S 310	**TAG S 310 NAC 449.3624 (p 11-12/13)** (Detail on page 12/13)	

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S 310	Continued From page 11 Findings include: Patient # 8 was admitted to the facility on 5/20/09 and readmitted on 5/30/09 after a two day acute hospital stay from 5/27/09 to 5/30/09. The patient's daignoses included status post mitral valve replacement, pacemaker,atrial fibrillation, chronic obstructive pulmonary disease, pancreatic pseudocyst, anemia, and leukocytosis. A document labeled Call Report Sheet indicated the patient had stage 1 and stage 2 pressure ulcers on the buttocks. A review of the medical record did not reveal a reassessment by the nursing staff on the readmission to the facility, nor was there evidence of the skin care resource team being utilized per wound assessment policy, nor was the protocol for saline dressings followed. There was no evidence of pressure relieving devices utilized for the patient. There was no evidence of treatment orders for the wounds on readmission other than barrier cream applied without a physician's order. Severity: 2 Scope: 1	S 310	**TAG S 310 NAC 449.3624 (p 11-12/13)** Assessment of Patient The correction plan for assessments of patients with wounds includes the following: a. Revision of existing Rehab wound care policy (REHAB.CID. 800) to correspond with skin integrity nursing care plan and the Renown Health skin care protocols. b. Comprehensive education of Rehab staff on wound care policy, documentation, and wound protocol (Remedial training session scheduled for 8/5/09 & 8/6/09) c. Implementation of assessment of patient condition, revised process for wounds scheduled to begin 8/10/09. d. Patients with impaired skin integrity are tracked on daily basis by night charge nurse. f. Monitoring of patient assessment and documentation for wound /skin integrity will be performed by weekly random chart audits (total 30/month) to begin 8/10/09. Attachments: **Tag S310 (p 11-12/13)** 1. Wound care policy for revision: REHAB.CID.800 2. Renown Health Skin/wound protocols (total12) 3. Impaired Skin integrity NCP **NOTE: Attachment: Currently being revised; attachments reflect partial changes and revisions.**	
S 405 SS=D	NAC 449.370 Outpatient Services 4. Equipment and supplies necessary to meet the anticipated needs of the outpatients must be readily available and in good working order. This Regulation is not met as evidenced by: Based on observation and interview the facility failed to ensure that when staff observed a frayed call light cord in the recovery room of the special procedures unit it was replaced. No working call lights were observed in the recovery room of the special procedures unit.	S 405	**TAG S 405 NAC 449.370 (p 12-13/13)** Outpatient Services Frayed call light cord in recovery room was replaced and working call lights were placed in special procedures recovery room on the day surveyors were in facility working. A monthly check list and monitoring for equipment has been developed and will be in place effective 8/1/09. **(See attachment Tag S 088 1) # 1, 2 (p 4/13))**	

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S 405	Continued From page 12 Severity: 2 Scope: 1	S 405		
S 519 SS=D	NAC 449.379 Medical Records 8. All medical records must document the following information, as appropriate: (a) Evidence that a physical examination, including a history of the health of the patient, was performed on the patient not more than 7 days before or more than 48 hours after his admission into the hospital. This Regulation is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a patient's history and physical within 48 hours for 1 of 21 sampled patients. Patient #4 was admitted to the hospital on 5/29/09, and did not have her history and physical completed until 6/1/09. Severity: 2 Scope: 1	S 519	**TAG S 519 NAC 449.379 (p 13/13)** Medical Records Effective 8/3/09 Each patient's clinical record will be reviewed by Health Information Management (HIM) staff within 24 business hours after admission to assess whether or not an appropriately documented history and physical (H&P) has been dictated. The delinquent H&P will be addressed in the following manner: 1. The standards for Rehab hospital H&P compliance will be forwarded to the attending physician staff at this facility by letter. 2. HIM department will review each patient's chart for H&P completion compliance and complete physician H&P notification log. 3. HIM Manager, or designee, will continue to advise the physician(s) on a daily basis until the H&P is dictated. 4. Administration, the Medical Director and Quality will be advised daily on the status of delinquent H&Ps. 5. HIM Manager will forward the monthly H&P compliance data by the 5th work day of the month to Administration, Medical Director and Quality. 6. Vice President/Administration and Medical Director will: (1) monitor compliance with H&P standards; (2) will review and discuss the H&P compliance at each monthly Medical Staff Quality Improvement Committee (MSQI) meeting, and the Medical Executive Committee (MEC) meeting. Attachments: **Tag S 519** 1. HIM Delinquent H&P notification log 2. Rehab H&P standard letter to physician	